215 ILCS 180/42 Health Care External Review Act

Sec. 42. External review of experimental or investigational treatment adverse determinations.

(a) Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for an external review with the Director.

(b) The following provisions apply to cases concerning expedited external reviews:

(1) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subsection (a) of this Section if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(2) Upon receipt of a request for an expedited external review, the Director shall immediately notify the health carrier.

(3) The following provisions apply concerning notice:

(A) Upon notice of the request for an expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements of subsection (d) of this Section. The health carrier shall immediately notify the Director and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(B) The Director may specify the form for the health carrier's notice of initial determination under subdivision (A) of this item (3) and any supporting information to be included in the notice.

(C) The notice of initial determination under subdivision (A) of this item (3) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Director.

(4) The following provisions apply concerning the Director's determination:

(A) The Director may determine that a request is eligible for external review under subsection (d) of this Section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(B) In making a determination under subdivision (A) of this item (4), the Director's decision shall be made in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(5) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subsection (d) of this Section, the Director shall immediately assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Director and notify the health carrier of the name of the assigned independent review organization.

(6) At the time the health carrier receives the notice of the assigned independent review organization, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(c) Except for a request for an expedited external review made pursuant to subsection (b) of this Section, within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to the health carrier.

(d) Within 5 business days following the date of receipt of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) the individual is or was a covered person in the health benefit plan at the time the health care service was recommended or requested or, in the case of a retrospective review, at the time the health care service was provided;

(2) the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) the covered person's health care provider has certified that one of the following situations is applicable:

(A) standard health care services or treatments have not been effective in improving the condition of the covered person;

(B) standard health care services or treatments are not medically appropriate for the covered person; or

(C) there is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment;

(4) the covered person's health care provider:

(A) has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(B) who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(5) the covered person has exhausted the health carrier's internal appeal process, unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to Section 30 of this Act; and

(6) the covered person has provided all the information and forms required to process an external review, as specified in this Act.

(e) The following provisions apply concerning requests:

(1) Within one business day after completion of the preliminary review, the health carrier shall notify the Director and covered person and, if applicable, the covered person's authorized representative in writing whether the request is complete and eligible for external review.

(2) If the request:

(A) is not complete, then the health carrier shall inform the Director and the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are required by this Act to make the request complete; or

(B) is not eligible for external review, then the health carrier shall inform the Director and the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

(3) The Department may specify the form for the health carrier's notice of initial determination under this subsection (e) and any supporting information to be included in the notice.

(4) The notice of initial determination of ineligibility shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director.

(5) Notwithstanding a health carrier's initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(f) Whenever a request for external review is determined eligible for external review, the health carrier shall notify the Director and the covered person and, if applicable, the covered person's authorized representative.

(g) Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted pursuant to this Section, within one business day after the date of receipt of the notice, the Director shall:

(1) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director pursuant to this Act and notify the health carrier of the name of the assigned independent review organization; and

(2) notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice

provided pursuant to item (2) of this subsection (g), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

(h) The following provisions apply concerning assignments and clinical reviews:

(1) Within one business day after the receipt of the notice of assignment to conduct the external review pursuant to subsection (g) of this Section, the assigned independent review organization shall select one or more clinical reviewers, as it determines is appropriate, pursuant to item (2) of this subsection (h) to conduct the external review.

(2) The provisions of this item (2) apply concerning the selection of reviewers:

(A) In selecting clinical reviewers pursuant to item (1) of this subsection (h), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 55 of this Act and, through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(B) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(3) In accordance with subsection (l) of this Section, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(4) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal appeal process.

(i) Within 5 business days after the date of receipt of the notice provided pursuant to subsection (g) of this Section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

(1) Except as provided in item (2) of this subsection (i), failure by the health carrier or its utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

(2) If the health carrier or its utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(3) Immediately upon making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (2) of this subsection (i), the independent review organization shall notify the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative of its decision to reverse the adverse determination.

(j) Upon receipt of the information from the health carrier or its utilization review organization, each clinical reviewer selected pursuant to subsection (h) of this Section shall review all of the information and documents and any other information submitted in writing to the independent review organization by the covered person and the covered person's authorized representative.

(k) Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall forward the information to the health carrier within one business day. In such cases, the following provisions shall apply:

(1) Upon receipt of the information, if any, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(3) The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

In such cases, the following provisions shall apply:

(A) Immediately upon making its decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the Director, the covered person and, if applicable, the covered person's authorized representative, and the assigned independent review organization in writing of its decision.

(B) Upon notice from the health carrier that the health carrier has made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

(l) The following provisions apply concerning clinical review opinions:

(1) Except as provided in item (3) of this subsection (l), within 20 days after being selected in accordance with subsection (h) of this Section to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to item (3) of this subsection (l), each clinical reviewer's opinion shall be in writing and include the following information:

(A) a description of the covered person's medical condition;

(B) a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(C) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(D) a description and analysis of any evidence-based standard; and

(E) information on whether the reviewer's rationale for the opinion is based on clause (A) or (B) of item (5) of subsection (m) of this Section.

(3) The provisions of this item (3) apply concerning the timing of opinions:

(A) For an expedited external review, each clinical reviewer shall provide an opinion orally or in

writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 5 calendar days after being selected in accordance with subsection (h) of this Section.

(B) If the opinion provided pursuant to subdivision (A) of this item (3) was not in writing, then within 48 hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under item (2) of this subsection (l).

(m) In addition to the documents and information provided by the health carrier or its utilization review organization and the covered person and the covered person's authorized representative, if any, each clinical reviewer selected pursuant to subsection (h) of this Section, to the extent the information or documents are available and the clinical reviewer considers appropriate, shall consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the covered person's health care provider's recommendation;

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier or its designee utilization review organization, the covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

(4) the terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

(5) whether (A) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition or (B) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(n) The following provisions apply concerning decisions, notices, and recommendations:

(1) The provisions of this item (1) apply concerning decisions and notices:

(A) Except as provided in subdivision (B) of this item (1), within 20 days after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, in accordance with item (2) of this subsection (n), shall make a decision and provide written notice of the decision to the Director, the health carrier, the covered person, and the covered person's authorized representative, if applicable.

(B) For an expedited external review, within 48 hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, in accordance with item (2) of this subsection (n), shall make a decision and provide notice of the decision orally or in writing to the Director, the health carrier, the covered person, and the covered person's authorized representative, if applicable. If such notice is not in writing, within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, the health carrier, the covered person, and the covered person's authorized representative, if applicable.

(2) The provisions of this item (2) apply concerning recommendations:

(A) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, then the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(B) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(C) The provisions of this subdivision (C) apply to cases in which the clinical reviewers are evenly split:

(i) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, then the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subdivision (A) or (B) of this item (2).

(ii) The additional clinical reviewer selected under clause (i) of this subdivision (C) shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions.

(iii) The selection of the additional clinical reviewer under this subdivision (C) shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers.

(o) The independent review organization shall include in the notice provided pursuant to subsection (n) of this Section:

(1) a general description of the reason for the request for external review;

(2) the written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(3) the date the independent review organization received the assignment from the Director to conduct the external review;

(4) the time period during which the external review was conducted;

(5) the date of its decision;

(6) the principal reason or reasons for its decision; and

(7) the rationale for its decision.

(p) Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(q) The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act.